MDR Tracking Number: M5-04-2874-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 05-03-04.

The IRO reviewed office visits with and without manipulations, therapeutic exercises, joint mobilization and manual therapy rendered from 06-04-03 through 09-02-03 that were denied based upon "U and V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-29-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99213 on date of service 05-02-03 and 05-05-03, CPT code 97110 dates of service 05-02-03, 05-05-03, 05-12-03 and 05-19-03, CPT code 97035 dates of service 05-02-03, 05-05-03, 05-07-03 and 05-12-03, CPT code 97014 dates of service 05-05-03 and 05-07-03 and CPT code 97250 on date of service 05-07-03 all denied with denial code "D" (duplicate). The Medical Review Division cannot determine the original reason for denial therefore no reimbursement is recommended for these services.

CPT code 97265 date of service 05-07-03 denied with denial code "F/M456" (maximum number of physical therapy services has been exceeded for this date of service). The maximum modalities of 4 (four) had been reached for date of service 05-07-03. No reimbursement recommended.

CPT code 97110 date of service 05-07-03 denied with denial code "F/M456" (maximum number of physical therapy services has been exceeded for this date of service). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of

the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Findings and Decision is hereby issued this 27th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

July 5, 2004

Rosalinda Lopez
Texas Workers’ Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2874-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review

Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: office notes, evaluations, treatment logs, PPE, radiology and neurology reports.
Information provided by Respondent: correspondence and designated doctor exam.

Clinical History:
Patient underwent physical medicine treatments and surgery after sustaining an on-the-job injury to her left shoulder on ___.

Disputed Services:
Office visits with and without manipulations, therapeutic exercises, joint mobilization and manual therapy during the period of 06/04/03 through 09/02/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
Physical medicine is an accepted part of a rehabilitation program following surgery. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (B) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (C) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment.

While six weeks of post-operative rehabilitation could be considered medically necessary, care beyond that time cannot be supported since the patient obtained no relief from the treatments, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment.

Specifically, the patient's pain rating was 4 on 04/17/03 at the initiation of post-surgical treatment, but she rated her pain at 5 near the end of care on 08/01/03. Moreover, the patient's left shoulder ranges of motion were essentially identical on 05/23/03 and again on 06/17/03, thus indicating that no functional or objective improvement occurred as a result of the additional treatment.